MOTION FILED

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No. 99-0936

In The
SUPREME COURT OF THE UNITED STATES

CRYSTAL FERGUSON, ET AL.,
Petitioners,

v.

CITY OF CHARLESTON, ET AL.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF *AMICUS CURIAE* OF THE RUTHERFORD INSTITUTE IN SUPPORT OF PETITIONERS

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June 2, 2000

316 PP

QUESTION PRESENTED FOR REVIEW

Whether the "special needs" exception to the Fourth Amendment's warrant and probable cause requirements was properly applied to a discretionary drug testing program targeting hospital patients that was created and implemented primarily for law enforcement purposes by police and prosecutors?

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS[1]

The Rutherford Institute hereby respectfully moves the Court for leave to file the following brief *amicus curiae* on behalf of Petitioners. Counsel for Petitioners has consented to the filing of this brief. The consent of counsel for Respondents was requested and refused.

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed petitions for writ of *certiorari* in the United States Supreme Court in more than two dozen cases, and *certiorari* has been accepted in two seminal First Amendment cases, *Frazee v. Dept. of Employment Sec.*, 489 U.S. 829 (1989) and *Arkansas Educational Television Comm'n. v. Forbes*, 523 U.S. 666 (1998). Institute attorneys have filed over three dozen *amicus curiae* briefs in the United States Supreme Court, including recent criminal justice cases *Wyoming v. Houghton*, 526 U.S. 295 (1999), *Slack v. McDaniel*, 120 S.Ct. 1595 (2000), *Illinois v. Wardlow*, 120 S.Ct. 673 (2000), and *Florida v. J.L.*, 120 S.Ct. 1375 (2000), as well as a multitude of *amicus curiae* briefs in the federal and state courts of appeals. Institute attorneys currently handle several hundred cases nationally, including numerous Fourth Amendment cases. The Institute has published educational materials and taught continuing legal education classes in this area as well.

The Rutherford Institute is submitting a brief *amicus curiae* in support of the Petitioners. In light of the important issues being raised in this case, the Institute respectfully requests that its arguments be

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[1] Counsel for The Rutherford Institute authored this brief in its entirety. No person or entity, other than the Institute, its supporters, or its counsel, made a monetary contribution to the preparation or submission of this brief.

heard.

Respectfully submitted,

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TO THE HONORABLE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

I. STATEMENT OF *AMICUS CURIAE* INTEREST AND INTRODUCTION[2]

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed petitions for writ of *certiorari* in the United States Supreme Court in more than two dozen cases, and *certiorari* has been accepted in two seminal First Amendment cases, *Frazee v. Dept. of Employment Sec.*, 489 U.S. 829 (1989) and *Arkansas Educational Television Comm'n. v. Forbes*, 523 U.S. 666 (1998). Institute attorneys have filed over three dozen *amicus curiae* briefs in the United States Supreme Court, including recent criminal justice cases *Wyoming v. Houghton*, 526 U.S. 295 (1999), *Slack v. McDaniel*, 120 S.Ct. 1595 (2000), *Illinois v. Wardlow*,120 S.Ct. 673 (2000), and *Florida v. J.L.*, 120 S.Ct. 1375 (2000), as well as a multitude of *amicus curiae* briefs in the federal and state courts of appeals. Institute attorneys currently handle several hundred cases nationally, including numerous Fourth Amendment cases. The Institute has published educational materials and taught continuing legal education classes in this area as well.

II. SUMMARY OF ARGUMENT

Respondent's clinical program of testing patients suspected of cocaine abuse without notice or consent and reporting the positive

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1 *Amicus curiae* The Rutherford Institute files this brief by leave of Court. Counsel for The Rutherford Institute authored this brief in its entirety, with able research assistance from Jennifer Addie (*B.A.*, Univ. of Va. 2000). No person or entity, other than the Institute, is supporters, or is counsel, made a monetary contribution to the preparation or submission of this brief.

results of such tests to law enforcement authorities cannot be justified as a "special needs" search. The program is not "justified at its inception" because it relies on a gross and unwarranted violation of the ages-old physician-patient confidential relationship, and is in derogation of accepted medical practice in the health care community. The program is not "reasonable in scope" because the inclusion of law enforcement officials in the program, and the inherent threat of prosecution, run counter to accepted health care policy and elevate the burden of suffering on both the mother and the unborn child, and because urinalysis testing has not been shown to be as effective as other accepted modalities in detecting and treating chronic drug abuse. Further, in view of the fundamental nature of the mother-infant relationship, the State cannot demonstrate a legitimate interest in protecting the unborn by testing maternity patients, absent probable cause or particularized suspicion to believe that a mother is engaged in drug abuse.

III. ARGUMENT

A. INTRODUCTION

Petitioners are ten women, most of them African-American, who sought gynecological care from physicians and/or health care workers at Respondent Medical University of South Carolina ("MUSC"), a state-run heath care facility in Charleston, South Carolina. *Ferguson v. City of Charleston*, Civ. No. 2:93-2624-2, U.S.D.C. Dist. S. Carolina, Findings of Fact, Conclusions of Law and Order dated September 29, 1997; Petition for Writ of Certiorari, Appx. A at A-37. Beginning in 1989, MUSC maintained a policy of conducting urinalysis testing for cocaine use by maternity patients who presented with any one or more of several indicia of possible drug abuse. *Id.* at A-37-38. Pursuant to the program, when any of these factors was present, a treating physician had no discretion to decline to order a drug urinalysis. *Ferguson v. City of Charleston*, 186 F.3d 469, 479 (4th Cir. 1999). The tests were conducted without obtaining a warrant, and pursuant to a general consent form that made no mention of the prospect of reporting the results to criminal

authorities. 186 F.3d at 486 (Blake, D.J., dissenting in part).

The factors mandating drug testing included prenatal care that is absent, late (care initiated after 24 weeks gestation), or regarded as incomplete (fewer than five visits); a history of cocaine use; *abruptio placentae* (separation of the placenta from the uterus); unexplained growth retardation or fetal death; and unexplained birth defects. 186 F.3d at 474. Where the urinalysis result was positive for cocaine use, the patient was reported to the City of Charleston Police Department and the patient was arrested for distributing cocaine to a minor. 186 F.3d at 474. While the policy was amended in 1990 to permit patients to elect to enter drug abuse treatment, a patient was still reported and monitored by the Solicitor General for compliance with treatment requirements if she failed to comply with treatment obligations or tested positive again. Hildebrand Test., Tr. at 124-26, 134-35. At issue in Petitioner's case, then, is the hospital's mandate that physicians and health care workers automatically test patients with any one of a battery of symptoms or conditions indicating possible drug abuse, and the report or threat of report of the alleged criminal behavior to police by hospital officials.

The State of South Carolina does not assert a "special needs" justification in identifying cocaine abuse for the purpose of prosecuting patients; in fact, it has expressly foresworn that rationale. Rather, it asserts that a special need, "apart from the interests of law enforcement," exists in treating maternal and fetal prenatal patients who may be subjected to cocaine abuse. Testing and reporting such patients, MUSC contends, are integral to the treatment of chronic cocaine abusers. Thus, MUSC asserts an interest grounded in health care policy, not criminal justice, to justify its program of testing and reporting patients for cocaine abuse. In essence, it seeks to establish a substantial and important governmental need to employ a particular modality of treatment that implicates patients' rights to privacy and to be free from unreasonable searches. The Court's *amicus* contends that MUSC's program of subjecting prenatal patients to invasive searches and criminal liability is a patently unreasonable means of

furthering the interests of government health care providers, and hence cannot pass muster under the "special needs exception" jurisprudence of this Court.

The Supreme Court has held that the taking of a urine sample and testing of the sample by urinalysis is unquestionably a "search" within the meaning of the Fourth Amendment. *Skinner v. Railway Labor Executives' Assn.*, 489 U.S. 602, 617 (1989); *Vernonia School Dist. 47J v. Acton*, 515 U.S. 646, 652 (1995).[3] In assessing the constitutional validity of such drug testing programs, the Court has not differentiated the initial taking of the urine sample as an independent "seizure," but rather treats it as a component of the Fourth Amendment search. *Skinner*, 489 U.S. at 618 ("In view of our conclusion that the collection and subsequent analysis of the requisite biological samples must be deemed Fourth Amendment searches, we need not characterize the employer's antecedent interference with the employee's freedom of movement as an independent Fourth Amendment seizure."). The Court's *amicus* will follow this convention. Likewise, in addressing the issue presented, the Court's *amicus* will not attempt to delineate its analysis of Petitioners' constitutional interests between the Fourth, Fifth and Fourteenth Amendments. The Rutherford Institute believes that Petitioners clearly possess a reasonable expectation that what they disclose to their physicians and health care workers will not be reported to criminal authorities for the purpose of "encouraging" them to abide by their treatment regimens. *See Katz v. United States*, 389 U.S. 347, 350 (1967), *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting). Likewise, the Court has repeatedly held that Fourteenth Amendment rights pertain in matters relating to control over decisions relating to reproduction and parental authority over minor children. *See, e.g., Griswold v. Connecticut*, 381 U.S. 479, 484-485 (1965), *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923). This approach is consistent with that taken by the Court in *Roe v*

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[3] "It is not disputed ... that chemical analysis of urine, like that of blood, can reveal a host of private medical facts about an employee, including whether he or she is epileptic, pregnant, or diabetic." *Skinner*, 489 U.S. at 618.

Wade and its progeny:

> The Constitution does not explicitly mention any right of privacy. In a line of decisions ... the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. In varying contexts, the Court or individual Justices have, indeed, found at least the roots of that right in the First Amendment, in the Fourth and Fifth Amendments, in the penumbras of the Bill of Rights, or in the concept of liberty guaranteed by the first section of the Fourteenth Amendment.

410 U.S. 113, 152 (1973) (citations omitted). This right of privacy, regardless of its source, "is broad enough to encompass" a woman's expectation of privacy in her communications to her doctor. *Roe*, 410 U.S. at 153.

The Supreme Court has emphasized that the Fourth Amendment is designed "to prevent arbitrary and oppressive interference by enforcement officials with the privacy and personal security of individuals." *United States v. Martinez-Fuerte*, 428 U.S. 543, 554 (1976). The Court has stressed that intrusions on the constitutionally protected right of privacy "should be judged by the standard of reasonableness under all the circumstances." *O'Connor v. Ortega*, 480 U.S. 709, 725-726 (1987). This standard requires a two-part inquiry: 1) Whether the search was "justified at its inception based upon reasonable, individualized grounds for suspecting the search will turn up evidence of misconduct," 480 U.S. at 726, citing *Terry v. Ohio*, 392 U.S. 1, 20 (1968); and 2) Whether the search was "reasonably related in scope to the circumstances which justified the interference in the first place," 480 U.S. at 726, citing *New Jersey v. T.L.O.*, 469 U.S. 325 (1985). The Rutherford Institute contends that the unauthorized drug testing conducted in this case was unreasonable both at inception and in the scope of its interference with the physician-patient relationship that gave rise to Petitioners' reasonable expectation of privacy, and therefore the Fourth Circuit Court of Appeals was in error in ruling that the "special needs exception" to the requirements of a warrant and probable cause justified Respondent's actions.

A. MUSC's DRUG TESTING AND REPORTING PROGRAM IS NOT "JUSTIFIED AT ITS INCEPTION" BECAUSE THE LACK OF OBJECTIVE TESTING CRITERIA AND THE OVERTLY CRIMINAL CONTEXT OF THE TESTING PROGRAM REQUIRE SOME FORM OF INDIVIDUALIZED SUSPICION UNDER THE COURT'S "SPECIAL NEEDS" JURISPRUDENCE

In assessing the quantum of suspicion required before a governmental agency may engage in a search and seizure outside the context of the criminal justice system, the Court has repeatedly stressed that "ordinarily, a search ... will be 'justified at its inception' when there are reasonable grounds for suspecting that the search will turn up evidence of misconduct." *O'Connor*, 480 U.S. at 726; *New Jersey v. T.L.O.*, 469 U.S. at 342, n. 8. In both *O'Connor* and *T.L.O.*, the Court found it unnecessary to decide whether "reasonable suspicion" was an element of the standard of reasonableness the Court adopted for the instant circumstances. *O'Connor*, 480 U.S. at 726; *New Jersey v. T. L. O.*, 469 U.S. at 342, n. 8. In the instant case, however, it is essential for the Court to determine whether reasonable suspicion or probable cause is a requisite component of "reasonableness" for the type of health care search and seizure urged by Respondents, insofar as Respondent does not contend that its protocol for identifying maternal patients who may be engaged in cocaine abuse is a "suspicion-based" system.[4] While it is certainly true that no irreducible requirement of individualized suspicion is imposed by the Fourth Amendment in all circumstances, *United States v. Martinez-Fuerte*, 428 U.S. at 560-561, *Camara v. Municipal Court*, 387 U.S. 523 (1967), the Court has nonetheless emphasized

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[4] Nor may it so contend, in view of the cases that have viewed as "suspicionless" similar non-uniform drug testing programs that searched only individuals considered "at risk" for potential drug abuse, *National Treasury Employees' Union v. Von Raab*, 489 U.S. 656 (1989), or only individuals involved in certain safety-sensitive positions or in certain circumstances. *See Skinner v. Railway Executives' Assn*, 489 U.S. at 609-610.

that "exceptions to the requirement of individualized suspicion are generally appropriate only where the privacy interests implicated by a search are minimal and where 'other safeguards' are available 'to assure that the individual's reasonable expectation of privacy is not "subject to the discretion of the official in the field."'" *New Jersey v. T.L.O.*, 469 U.S. at 342, quoting *Delaware v. Prouse*, 440 U.S. 648, 654-655 (1979) (citations omitted). MUSC's policy does not admit of such exceptions, in view of the serious encroachment it makes upon historically cherished privacy interests and the absence of objective criteria for determining which patients are subjected to drug urinalysis.

Respondent's program tests only a restricted group of women who display signs or symptoms consistent with drug abuse; no protections are present to guard patients from abuses arising from discretionary testing and reporting. While Respondent argues that the policy's requirement of testing all patients who meet the criteria eliminates the risk of discriminatory application, this is far from true. In fact, the testing criteria are predominantly subjective, as factors such as "unexplained growth retardation" and "unexplained birth defects" require the exercise of clinical judgment. Nor are the criteria conducive to identifying a discrete class of individuals who may need to be subjected to testing based on governmental "special needs," as in *Skinner* and *Von Raab* as several of the testing factors (such as growth retardation) are consistent with symptoms displayed by a substantial portion of the maternal patient population. Governmental testing policies that define "reasonable suspicion" in a manner that does not restrict the predicate factors to objective, verifiable criteria have been repeatedly struck down by the lower federal courts as unconstitutionally vague and overbroad.[5] *See, e.g., National Treasury Employees Union v. Yeutter*, 918 F.2d 968, 972-73 (D.C. Cir. 1990) (Dept. of Agriculture); *Bangert v. Hodel*, 705 F.Supp. 643, 650 (D.D.C. 1989) (Dept. of the Interior); *American Fed'n of*

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[5] The federal agencies' regulations stated that "[r]easonable suspicion" may be based on, "among other things," "observable phenomena" or "a pattern of abnormal conduct or erratic behavior." *See generally* cases *infra*.

Gov't Employees v. Sullivan, 744 F.Supp. 294, 302-303 (D.D.C. 1990) (Dept. of Health and Human Services); *National Federation of Federal Employees v. Cheney*, 742 F.Supp. 4, 6 (D.D.C. 1990) (Defense Mapping Agency). In particular, the use of *ad hoc* means of finding reasonable suspicion (*e.g.*, the use of catchall clauses such as "among other things") was summarily rejected in *Hodel*. 705 F.Supp. at 651 (holding government's only legitimate interest is in on-duty drug use or drug-related job impairment supported by evidence of specific, personal observations concerning performance, appearance, behavior, etc.). In view of the egregious violation of patients' expectation of the right to consent and to privacy, and the lack of objectivity inherent in Respondent's program, the program cannot be deemed a reasonable "special needs" search.

B. MUSC'S DRUG TESTING AND REPORTING PROGRAM IS UNREASONABLE IN SCOPE IN LIGHT OF THE VIOLATION OF PHYSICIAN-PATIENT CONFIDENTIALITY IT PERPETRATES

In assessing the reasonableness of the scope of a search, "[t]he first factor to be considered is the nature of the privacy interest upon which the search . . . at issue intrudes." *Vernonia*, 515 U.S. at 654. The Fourth Amendment does not protect all subjective expectations of privacy, but only those that society recognizes as "legitimate." *New Jersey v. T.L.O.*, 469 U.S. at 338. "What expectations are legitimate varies, of course, with context." *Id.*, at 337. The legitimacy of a privacy expectation also depends in large measure upon the individual's legal relationship with the State. The Court's decision in *Vernonia, supra*, for example, turned principally upon the fact that the subjects of the drug testing policy were children, who had been "committed to the temporary custody of the State as schoolmaster." 515 U.S. at 654. The State's role as schoolmaster, the Court noted, "permitt[ed] a degree of supervision and control *that could not be exercised over free adults*." *Id.* (emphasis supplied). In Petitioners' case, the relationship of physician and patient gave rise to a

heightened expectation of privacy, and a legitimate expectation that drug testing would not be done without knowledge and consent.

Without a doubt, government physicians, like all doctors, have not only the right, but moreover the duty, to inquire about suspected drug abuse with their patients. This is unquestionably a health issue. This duty becomes all the more pronounced in the context of obstetric care, in which the physician assumes duties of care toward both the maternal and fetal patients. The American College of Obstetricians and Gynecologists (ACOG) guidelines on ethical decision-making state:

> In the care of the obstetric patient, the traditional physician-patient relationship expands to include the fetus. The physician retains an obligation to respect the autonomy of the pregnant woman while promoting her medical well-being. In addition, the physician must assume an obligation of beneficence (promoting the well-being of others) toward a second patient, the fetus. The weight that this obligation is given in comparison with previously established obligations to the woman is central to many ethical dilemmas in the practice of obstetrics.[6]

In view of this dual obligation, and of the risks presented by drug abuse toward both patients, counseling patients against drug use is recommended as a standard intervention for periodic health examinations of pregnant women by the American Medical Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists and the U.S.

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6 "Ethical Decision-Making in Obstetrics and Gynecology," ACOG Technical Bulletin No. 136, November, 1989.

Preventive Systems Task Force.[7] Routine screening for drug abuse with standardized questionnaires or biologic assays (with informed consent) is recommended for all pregnant women by the Task Force.[8] The Task Force's guidelines for screening for drug abuse state that "[t]he diagnostic standard for drug abuse and dependence is the careful diagnostic interview."[9] Patient history information should include the quantity, frequency and pattern of drug use, as well as any adverse effects of drug use on work, health and social relationships.[10] "A careful history taken by trusted clinicians remains the most sensitive means of detecting drug use and abuse ...."[11] In fact, "clinical history may be more useful than toxicologic testing for identifying newborns at risk: among drug-exposed infants identified by meconium testing, adverse outcomes were limited to infants born to mothers who admitted to drug use."[12] The Task Force cautioned against the adverse effects of nonconsensual toxicological screening:

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7 *See* American Medical Assn., "Drug Abuse in the United States: A Policy Report," Board of Trustees Report (1988); American Academy of Family Physicians, "Age Charts for Periodic Health Examination," Reprint No. 510 (1994); American College of Obstetricians and Gynecologists, "Substance Abuse in Pregnancy," Technical Bulletin No. 195 (1994); U.S. Preventive Systems Task Force, Guide to Clinical Preventive Services (2d ed. 1995).

8 U.S. Preventive Systems Task Force, *supra*, Appdx. A, Table 53.

9 Guide to Clinical Preventive Services, supra, Chapter 53, citing American Psychiatric Assn., Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994).

10 *Id.*

11 *Id.*, citing E.M. Ostrea et al., "Drug Screening of Newborns by Meconium Analysis: A Large-Scale, Prospective Epidemiologic Study," 89 Pediatrics 107 (1992).

12 *Id.*

> Drug testing is frequently performed without informed consent in the clinical setting on the grounds that it is a diagnostic test intended to improve the care of the patient. Because of the significance of a positive drug screen for the patient, however, the rights of patients to autonomy and privacy have important implications for screening of asymptomatic persons. If confidentiality is not ensured, test results may affect a patient's employment, insurance coverage, or personal relationships. Testing during pregnancy is especially problematic, because clinicians may be required by state laws to report evidence of potentially harmful drug or alcohol use in pregnant patients.[13]

In assessing the level of the intrusion on privacy interests in *O'Connor v. Ortega*, *supra*, the Court relied in part on the absence of evidence that the employer had established any reasonable regulation or policy discouraging employees from storing personal items in their offices. 480 U.S. at 719. Conversely, "courts have decided that an employee had no such expectation [of privacy] with respect to a workplace search because an established regulation permitted the search." 480 U.S. at 738 (Blackmun, J., dissenting). In this case, the right of medical patients to expect privacy in the patient-physician relationship is better established than virtually any other privacy expectation, and it has been codified in various policy statements by the medical profession, governmental agencies and patient advocate organizations.

A physician's duty of loyalty and trust to his or her patient has been established in medicine from time immemorial, since at least the articulation of the Oath of Hippocrates (c.~400 B.C.). According to the American Medical Association ("AMA"):

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13 *Id.*, citing J.C. Merrick, "Maternal Substance Abuse During Pregnancy: Policy Implications in the United States," 14 J. Legal Med. 57 (1993).

> The duty of confidentiality constitutes an integral part of professional ethics, and is featured in virtually every oath of medicine, most prominently the Hippocratic Oath: "What I may see or hear in the course of treatment, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about." ....Confidentiality is critical in health care because it is a vital prerequisite for trust and honesty in the patient-physician relationship; it allows patients to seek medical care and disclose sensitive details openly with their physicians without fear of consequences.[14]

The AMA Principles of Medical Ethics,[15] II and IV among others, mandate physician-patient trust as the foundation for medical treatment. The Second Principle provides that "[a] physician shall deal honestly with patients ..." The Fourth obligates a physician to "respect the rights of patients ... [and] safeguard patient confidences within the constraints of the law." This obligation is also codified in the AMA's Fundamental Elements of the Patient-Physician Relationship, which state in pertinent part:

> From ancient times, physicians have recognized

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[14] Report of the Board of Trustees of the American Medical Association, 9, A-98, citing Reich WT, ed., "Medical Codes and Oaths: Ethical Analysis." Encyclopedia of Bioethics, New York, Simon & Schuster, 1995, p. 1429.

[15] The AMA's Principals of Medical Ethics establish the core ethical principals that serve as the foundation for the AMA's Code of Ethics, which includes the Principles as well as other documents such as the Fundamental Elements of the Patient-Physician Relationship. AMA, Current Opinions of the Council on Ethical and Judicial Affairs (1980).

> that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physician in a mutually respective alliance.[16]

The Fundamental Elements urge physicians to contribute to this physician-patient alliance "by serving as their patients' advocate and by fostering [patients'] rights. "A number of these rights are implicated by Respondent's policy of unauthorized testing and reporting, including "the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives" (Fundamental Elements, No. 1); the right to "have their questions answered [and] to be advised of potential conflicts of interests that their physician may have; (Fundamental Elements, No. 1); and the right to "accept or refuse any recommended medical treatment" (Fundamental Elements, No. 2). Most significantly, patients possess the right to confidentiality. "The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest." (Fundamental Elements, No. 4).

In view of this duty, "The AMA has insisted that conflicts between a patient's right to privacy and a third party's 'need to know'

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16 AMA, Fundamental Elements of the Patient-Physician Relationship (herein "Fundamental Elements"), Report of the Council on Ethical and Judicial Affairs of the American Medical Association (originally adopted June 1990, updated June 1994).

be resolved to the patient's benefit, 'except where that would result in serious health hazard or harm to the patient or others.'"[17] The AMA Council on Ethical and Judicial Affairs elaborates:

> The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.[18]

The AMA Board of Trustees has affirmed that "Disclosures of information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, *except in those cases in which the third party has a legal or predetermined right to gain access* to such information."[19]

Although AMA policy permits exceptions, none are applicable to the instant issue. Disclosures are permitted where "required by

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[17] Board of Trustees Report 9-A-98, quoting AMA Policy H-140.989.

[18] Current Opinions of the Council on Ethical and Judicial Affairs, E-5.05 (Issued December 1983; updated June 1994).

[19] Current Opinions of the Council on Ethical and Judicial Affairs, H-140.989(7), "Informed Consent and Decision-Making in Health Care," Board of Trustees Report NN, A-87 (reaffirmed, Sunset Report, I-97)(Emphasis added).

law,'" such as in the case of violent criminal activity[20] or communicable disease reporting.[21] The only disclosures to police authorities permitted (though not required) by the policy are disclosures made to discharge a physician's duty to a patient or third parties where the patient has threatened violence.[22] MUSC's testing

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20 "[G]un shot and knife wounds should be reported *as required by applicable statutes or ordinances.*" Current Opinions of the Council on Ethical and Judicial Affairs, E-5.05, *supra* (emphasis added.) Some jurisdictions mandate reporting of narcotic use by statute. Trandel-Korenchuk, D.M. & Trandel-Korenchuk, K.M., "Collection and Disclosure of Patient Information," in Nursing and the Law, 127-160 (Aspen 1997). Likewise, all but five jurisdictions require reporting of domestic violence in varying circumstances. Hyman, et al., "Laws Mandating Reporting of Domestic Violence: Do They Promote Patient Well-Being?" 273(22) JAMA 1781 (1995). In contrast to MUSC's policy, however, these are legislated duties, passed after due consideration to competing interests of physicians, patients and law enforcement authorities.

21 "[C]ommunicable diseases ... should be reported *as required by applicable statutes or ordinances*." *Id.* (Emphasis added.)

22 "Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, *including notification of law enforcement authorities*." *Id.* (Emphasis added.) In addition to serving important patient protection interests, this provision of the policy permits a physician to absolve himself or herself of the burden of potential liability under such circumstances. *See, e.g., Tarasoff v. Regents of the University of California*, 17 Cal.3d 425, 131 Cal.Rptr. 14, 551 P.2d 334 (1976) (plaintiffs could state cause of action against defendant therapists for failure to warn third party of threat by patient; special relationship to patient was extended to victim, and therapists had duty to use reasonable care to warn victim of danger). *Cf.* Ferris, L., et al.,

and reporting policy was voluntarily promulgated and adopted by a committee of health care workers and criminal justice officials, not mandated by law.

The AMA recently reviewed and reaffirmed these "key principles" relating to patient privacy and confidentiality. The Association affirmatively repudiated any broad right of access to confidential patient information by law enforcement agencies:

> (2) Our AMA affirms:
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> * * * *
>
> (c) that physicians should not be required to report any

"Defining the Physician's Duty to Warn: Consensus Statement of Ontario's Medical Expert Panel on Duty to Inform," 158(11) CMAJ 1473 (1998) (analyzing *Tarasoff* decision and recommending an obligation to warn third parties under such circumstances).

Nonetheless, there remain countervailing considerations of liability for practitioners who elect to divulge sensitive information. In the opinion of the AMA's Office of General Counsel (Division of Health Law), while the AMA's ethical guidelines are not binding as law:

> maintaining patient confidentiality is a legal duty as well as an ethical duty. A physician's legal obligations are defined by the U.S. Constitution, by federal and state laws and regulations, and by the courts. Even without applying ethical standards, courts generally allow a cause of action for a breach of confidentiality against a treating physician who divulges confidential medical information without proper authorization from a patient.

Statement on Patient Confidentiality, AMA, Office of General Counsel (Division of Health Law) (1998).

> aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be *required by law*.[23]

While the AMA acknowledges that breaches of confidentiality may be compelled by concerns for public health and safety, it stresses that "those breaches must be as narrow in scope and content as possible; must contain the least identifiable and sensitive information possible; and must be disclosed to the fewest possible to achieve the necessary end."[24] Further,

> Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains.[25]

Clearly, Petitioners have the weight of millenia of medical philosophy and practice on their side of the balance. That history is what distinguishes Petitioners' valid expectation of privacy against

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23 Current Opinions of the Council on Ethical and Judicial Affairs, H-315.983, "Patient Privacy and Confidentiality," Board of Trustees Rep. 9, A-98 (Reaffirmation I-98; Appended: Res. 4, and Reaffirmed, Board of Trustees Rep. 36, A-99).

24 *Id.*

25 *Id.*

urinalysis testing and reporting from the type of everyday encounter with an airport or courtroom metal detector or a border check. It is more than the expectation of personal privacy that arises out of modesty; it is the expectation that a health care facility and a treating physician and staff are trustworthy confidants. More than the act of taking urine for testing without consent is at stake. What is at stake is the expectation that our doctors will not work against us and on behalf of the state. Although it is questionable that MUSC's policy of treating drug abuse by threatening arrest, if initiated by a private health care service, would amount to an improper invasion of constitutionally protected privacy, it is precisely MUSC's position as a government agent that subjects it to the constraints of the Fourth Amendment. *See O'Connor*, 480 U.S. at 715 (where government acts an employer, it is subject to the Fourth Amendment); *New Jersey v. T.L.O.*, 469 U.S. at 333; *Vernonia*, 515 U.S. at 652 (government subject to Fourth Amendment in discharging its public educational function); *Chandler v. Miller*, 520 U.S. 305 (1997) (state electoral system subject to Fourth Amendment constraints). Respondent's physicians took upon themselves an oath and an ethical obligation to respect patient confidentiality that, far from being disspelled or diminished by the fact that they were government actors, was actually *augmented* thereby, since to the constraints of medical ethics were added the constraints of the Fourth and Fourteenth Amendments.

C. RESPONDENT CANNOT ASSERT A LEGITIMATE GOVERNMENTAL INTEREST IN EMPLOYING UNAUTHORIZED DRUG TESTING AND REPORTING, SINCE SUCH "THERAPY" IS NOT A RECOMMENDED MODALITY IN THE HEALTH CARE PROFESSION.

Essentially, what Respondent asserts as a "special need" is the right of a government doctor to employ a modality for treatment of drug abuse that is contrary to accepted medical practice relating to patient drug abuse. According to the Centers for Disease Control and

Prevention, "[r]outine measurement of biochemical markers, such as serum GGT, and drug testing of urine or other body fluids are not recommended as the primary method of detecting alcohol or other drug abuse in asymptomatic persons."[26] In particular, "it has not been demonstrated in a controlled setting that the detection and treatment of alcohol and other drug abuse through screening asymptomatic persons can produce a better outcome than conventional treatment after signs and symptoms become apparent."[27] Additionally, "Urine testing is sensitive and specific for recent drug use but has many limitations as a routine screening test: it does not distinguish occasional use from drug abuse or dependence; sensitivity and specificity vary with timing of drug use; and the effectiveness of early intervention has not been examined in asymptomatic drug users detected by toxicologic screening."[28] On balance, "a careful history remains the best way to identify those who need [drug abuse] treatment." [29]

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[26] Centers for Disease Control and Prevention, "Recommendations on Screening," http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000109/entire.htm#head052000000000000.

[27] *Id.*

[28] *Id.*, citing D.J. Greenblatt and R.I. Shader, "Say 'No' to Drug Testing," 10 J. Clin. Psychopharmacology 157 (1990).

[29] *Id.* Respondent's clinical approach, which adopts an outlook of paternalism toward the maternal and fetal patient, has been largely rejected by the medical community. The universally recognized guideline of nonmalificence urges practitioners to avoid causing harm and to prevent serious harm. B. Lo, Resolving Ethical Dilemmas: A Guide for Clinicians (1994). The related guideline of beneficence obligates physicians to act for the greater good of patients. *Id.* Nonetheless, where nonmalificence and beneficence conflict with patient autonomy, paternalism has been rejected in favor of patient authority. T.L. Beauchamp and J. Childress, *Principals of Biomedical Ethics* (3d ed. 1989). "It is now accepted that competent,

Furthermore, the State's mode of "treatment" actually *elevates* the burden of suffering on the maternal patient by imposing the considerable mental and emotional distress of pending prosecution, and hence elevates the burden on the fetal patient as well. *See Caban v. Mohammed*, 441 U.S. 380, 405 (1979) (Stevens, J., dissenting), citing 1&2 J. Bowldy, Attachment of Loss (1969, 1973); M. Mahler, The Psychological Birth of the Human Infant (1975).[30]

The test for "reasonableness" turns upon whether a "reasonable" actor under the circumstances would order the search. *Vernonia*, at 665, citing *O'Connor, supra*, 480 U.S. 709 ("just as when the government conducts a search in its capacity as employer ..., the relevant question is whether that intrusion upon privacy is one that a reasonable employer might engage in, so also when the government

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informed patients should retain the power to decide what is in their best interests. Participating in decisions increases patients' sense of control, self-determination, and adherence to care plans." A. Hyman, et al., "Laws Mandating Reporting of Domestic Violence: Do They Promote Patient Well-Being?" 273 (22) JAMA 1781 (1995).

[30] *Cf. Roe v. Wade*, 410 U.S. at 153, which took into consideration the mental and emotional distress consequent to a woman's decision whether to elect an abortion:

> The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it.

acts as guardian and tutor the relevant question is whether the search is one that a reasonable guardian and tutor might undertake"). The Court's *amicus* submits that in view of the egregious violation of patient confidentiality engendered by MUSC's drug testing program, and the availability of a host of other modalities for diagnosis and treatment of drug-abusing patients, this is not a search a "reasonable doctor" (such as a private physician in similar circumstances) would order. The "reasonable physician" approach gives government physicians and health care workers the authority of private practitioners, no more and no less. That is all that is required to discharge their duties as health care providers. *Cf. Arkansas Educational Television Comm'n v. Forbes*, 523 U.S. 666 (1998) (public broadcasters possess only those limited First Amendment rights accorded private broadcasters).

D. ABSENT PROBABLE CAUSE OR INDIVIDUALIZED SUSPICION TO BELIEVE THE MATERNAL PATIENT IS ENGAGED IN COCAINE ABUSE, RESPONDENT CANNOT DEMONSTRATE AN INDEPENDENT INTEREST IN THE TESTING OF PREBORN MINORS AS AGAINST THE MATERNAL PATIENT'S RIGHT TO DIRECT AND CONTROL THE MEDICAL TREATMENT OF THE MINOR PATIENT.

The Rutherford Institute has no serious doubt that an important governmental interest exists in counteracting intrauterine drug transfer, both as a criminal matter and a health matter. *Vernonia*, 515 U.S. at 660-61 (deterring drug use by schoolchildren an "important," "perhaps compelling" concern); *Skinner, supra*, 489 U.S. at 628 ("compelling" interest in deterring drug use by railway workers); *Treasury Employees v. Von Raab*, 489 U.S. at 668 ("compelling" interest in deterring drug use by Customs agents); *Michigan Dept. of State Police v. Sitz*, 496 U.S. 444, 451 (no serious dispute about magnitude of drunken driving problem or state's interest in eradicating

it). Nor does the Institute, as a leading organization in the pro-life movement, have any doubt about the importance of the governmental interest in protecting the unborn. *Roe v. Wade*, 410 U.S. at 162 (recognizing the State's "important and legitimate interests in preserving and protecting the health of the pregnant woman [and] in protecting the potentiality of human life"); *Planned Parenthood v. Casey*, 505 U.S. 833, 875-76 (1992) ("there is a substantial state interest in potential life throughout pregnancy"); But Respondent's attempt to justify the City of Charleston's policy of drug testing pregnant mothers by its interest in their preborn minor children is a constitutional *non sequitur*, since both before and after birth, parents possess a Fourteenth Amendment right to direct and control their children's medical care as well as other significant aspects of nurture, education and upbringing. *See Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). A mother's relationship with her child, whether born or unborn, is considered a fundamental right that cannot be denied absent due process. *Santosky v. Kraemer*, 455 U.S. 745, 753, 759 (1982); *Lassiter v. Dept. of Soc. Serv.*, 452 U.S. 18, 27 (1981); *Glona v. American Guar. & Liab. Ins. Co.*, 391 U.S. 73 (1968). Although the interests of the State in protecting children may override parental rights in the presence of probable cause to suspect abuse (necessitating intervention by child protective services authorities or, in appropriate cases, law enforcement officials), in the absence of such particularized suspicion, the rights of parents must control. *Cf. Vernonia*, 515 U.S. at 650 (drug testing conducted on minor students only with notice to and consent of parents). While the State may have in interest in combating prenatal drug abuse, this is a relatively recent interest in jurisprudence. An interest newly assertable is not protectible if it derogates a substantive liberty interest traditionally recognized as protectible. *Smith v. Org. of Foster Families*, 431 U.S. 816, 846 (1977). Conflict between perceived interests must be resolved by the one giving way to the deeply rooted and traditionally recognized right. *Michael H. v. Gerald D.*, 419 U.S. 110, 128-31 (1989).

Conversely, a government employer's interest in conducting a

search receives significantly reduced constitutional consideration where, as here, the search was not in the nature of the type of "administrative" employer search sanctioned by the Court in *O'Connor v. Ortega*, but rather was clearly a "search for evidence of criminal misconduct." 480 U.S. at 721. In fact, the Court noted in that case, "The only cases that imply that a warrant should be required involve searches that are not work related ... *or searches for evidence of criminal misconduct*." 480 U.S. at 721 (citations omitted). There is no demonstration on the record herein of an attempt by Respondent MUSC to initiate and develop other clinical modalities for treatment of the problem. It was regarded as a criminal problem from the outset and treated thusly. In *Skinner*, *Von Raab* and *Vernonia*, it was considered a saving grace of the drug-testing programs under review was that the results were not turned over to law enforcement authorities. *Skinner*, 489 U.S. at 626-27; *Von Raab*, 489 U.S. at 663; *Vernonia*, 515 U.S. at 658. It is doubtful the Court would have reached the same result in those cases if the respective policies of the rail transit system, the Customs Department and the school system had mandated reporting of positive results to local police and the threat of prosecution as an "incentive" for employees and student athletes to remain drug-free.

Further, there is no indication on the record that the standard interview screening and counseling recommended by the AMA and other health care agencies would not have accomplished effective diagnosis and treatment. Where cocaine use was admitted by a patient, Respondent would have the identical range of treatment options available to it. Where it was denied, but clinical or historical information indicated otherwise, it could still have requested consent for a urinalysis; confronted the patient with the diagnostic indications of drug abuse; and counseled the patient against drug abuse or recommended inpatient therapy if the staff believed patients were not forthcoming.

CONCLUSION

Based on the foregoing, the Court's *amicus* respectfully suggests that the decision of the Fourth Circuit Court of Appeals be reversed and the case remanded to the appeals court for a determination whether the issue of consent was properly submitted to the jury or whether the verdict was supported by the evidence. 186 F.3d at 476 (finding it unnecessary to determine those issues in view of ruling that "special needs exception" applied). However, in keeping with a patient's reasonable expectation of privacy in her medical records and her communications to her doctor, the Court should instruct the Court of Appeals that consent may not be deemed to have been given absent a specific written waiver documenting the patient's fully informed consent.[31]

Respectfully submitted,

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[31] *See* Current Opinions of the Council on Ethical and Judicial Affairs, H-315.983, "Patient Privacy and Confidentiality," *supra* (cautioning against the use of "overbroad consent forms" and requiring waiver of patient's right to privacy "in a meaningful way"); Statement on Patient Confidentiality, AMA, Office of General Counsel, *supra* (requiring that a valid general release include the "identity of the party to be furnished information" and warning that "[g]eneral releases will not suffice for records containing HIV or other sensitive material").